EMPLOYEE REPORT of ACCIDENT/INJURY

The employee must complete this report as soon as possible following an accident/injury. This report will be provided to the supervisor within 24 hours of the accident/injury.

Name: _____ **Date of Injury:** _____ **Time of Injury:** _____ **AM PM**

Social Security # _____ **Date of Birth:** _____ **Work Phone #** _____ **Home Phone #** _____

☐ **Full Time** ☐ **Part Time** **Date Employed:** _____ **Dept/Div:** _____

Home Address: _____

Shift: A ☐ **B** ☐ **C** ☐ **Start Time of Work Day:** **:** **AM PM**

Witnesses (attach statement for each)

Name: _____ **Title:** _____ **Phone Number:** _____

Name: _____ **Title:** _____ **Phone Number:** _____

Name: _____ **Title:** _____ **Phone Number:** _____

Exact Location Injury Occurred: **Duties Being Performed:**

Describe the circumstances causing the injury:

_____

_____

_____

_____

Personal Protection Equipment Used:

☐ **Foot Protection.** ☐ **Face/Eye Protection.** ☐ **Fall Protection.** ☐ **Respiratory Protection.** ☐ **Hand Protection.**

☐ **Head Prot.** ☐ **Apron/Chaps** ☐ **Back Belt** ☐ **None** ☐ **Lifting Assistance Device**

☐ **Other:** **Object, equipment, or substance, which caused injury:**

Choose factor (s), which directly or indirectly caused the accident to occur:

☐ **Struck by Flying/Thrown Object** ☐ **Caught in/Under/Between Objects** ☐ **Temperature Extremes**

☐ **A Fall** ☐ **Struck by an Object/Person** ☐ **Rubbed or Abraded by Object**

☐ **Bodily Reaction** ☐ **Electric Shock** ☐ **Struck Against Object**

☐ **Blood/Fluid Exposure** ☐ **Other Disease Exposure** ☐ **Noise Exposure**

☐ **Vehicle/Equipment Accident** ☐ **Toxic Material Exposure** ☐ **Repetitive Motion**

☐ **Client Caused** ☐ **Client Assault** ☐ **Other-Describe**

Nature of Injury:

☐ **Head** ☐ **Trunk** ☐ **Digestive** ☐ **Eye (s) R L B** ☐ **Wrist(s) R L B** ☐ **Ankle(S) R L B**

☐ **Neck** ☐ **Abdomen** ☐ **Respiratory** ☐ **Shoulder(s) R L B** ☐ **Finger(s) T I M R P** ☐ **Foot/Feet R L B**

☐ **Chest** ☐ **Groin** ☐ **Circulatory** ☐ **Arm (s) R L B** ☐ **Hip(s) R L B** ☐ **Toe(s) R L B**

☐ **Back** ☐ **Skin** ☐ **Hand (s) R L B** ☐ **Other-Describe:**

Medical Treatment:

☐ **No Treatment** ☐ **First Aid** ☐ **Employee Health Clinic** ☐ **Outside Medical Treatment**

Employee's Signature: _____ **Title:** **Date:** _____

Supervisor's Signature: **Title:** **Date:**

Distribution:

DHHS S&B Form 3010 E (06/30/09)

CORVEL

WC Authorization | Physician's Report | Pharmacy Guide

MAILING ADDRESS: P.O. Box 77880, Charlotte, NC 28271
800-365-5998 www.corvel.com

EMPLOYER: Please complete the top section and give to the injured employee to take with them to their authorized treating physician. If you already have transitional duty job descriptions available, please attach a copy for the treating physician's review.

Name of Employee: **Last:**	**First:**
Date of Injury:	
Name of Employer:	
Employer Signature:	Treating Physician:

EMPLOYEE: Please take this form with you to an authorized treating physician. Please have the physician complete the middle section and return this immediately to your employer. The bottom section is for you to show the pharmacist should you need to have any prescriptions filled as prescribed by your authorized treating physician for this work related injury.

AUTHORIZED PHYSICIAN, PLEASE COMPLETE

Diagnosis: _____

A post accident drug test (check one) ( ) **has** been completed ( ) **has not** been completed

In accordance with this patient's physical capability, check all that apply:

( ) May resume work immediately, no restriction.
( ) May resume work immediately with the following restrictions:
- ( ) Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
- ( ) Light work (lifting less than 20 pounds)
- ( ) Medium work (lifting less than 50 pounds)
- ( ) Heavy work (lifting less than 100 pounds)
- ( ) Normal shift
- ( ) Limited hours: ____ hrs, _____hrs, _____hrs per day
- ( ) Other: _____

( ) Repetitive Motion Restrictions (specific to hand/arm injuries):

Frequency	**Left**	**Right**
No Use		
Occasional <33% of time		
Frequent 34-66% of time		
Regular 67-100% of time		

( ) Patient may return to work at full duty on (date) _____
( ) Patient has a return appointment on (date) _____at (time) _____

Please indicate any referrals that are required: _____

Physician's Signature	**Date**	**Physician's Name (type or print)**

Physician Offices – Be sure to contact CorVel's Claim Department at 800-365-5998 for authorization for the referral.

PHARMACIST: Process all prescriptions online through ***CorVel's pharmacy program*** for this patient. Contact the Help Desk at (800) 563-8438 to establish eligibility prior to processing online from 8:00 am thru 9:00 am Eastern. After hours, please contact (800) 213-5640.

DO NOT CHARGE THE PATIENT FOR THE PRESCRIPTION.

CHAIN NAME	CHAIN NAME	CHAIN NAME	CHAIN NAME
Bi-Lo Pharmacy	Horizon Pharmacy	Revco drugs	VIX Pharmacy
Bi-Mart	HyVee Drugtown	Rite-Aid drugs	Walgreen's
Brooks Drugs	J & J Pharmacy	RX Discount Pharmacy	Wal-Mart Pharmacy
Brookshire Brothers	Joel & Jerry's	Sack-n-Save	Wegman Pharmacy
Cub Pharmacy	Kash N Karry	Sav-A-Lot	Winn-Dixie
CVS Drugs	Kerr Drugs	Sams Club Pharmacy	
Drug Emporium	K-mart phcy	Save Mart	
Eckerds(all others)	Long's Phcy	Stop N Shop	
Franck's Pharmacy	Medicine Shoppe	Super D	
Fred Meyer	Medistat Phcy	Super Valu	
Fred's Pharmacy	Milner-Rushing Drugs	Super X (HSI)	
Giant Pharmacy	Pathmark Pharmacy	Tom Thumb Phcy	
Goodings	Perry Drg Str	Tops Pharmacy	
Hannaford Food &	Phar-Mor	Tri Daly Drugs	

Group Number: RXFFWC310
CCRx BIN: 900020
PCN: CLAIMNE
Dept. of Health and Human Services

CORVEL

*** All participating pharmacies have not bee included on this list. Please have your pharmacy call regarding any questions/ authorizations 800-563-8438.**

SUPERVISOR'S INVESTIGATION OF EMPLOYEE ACCIDENT/INJURY

This report will be provided to the Workers' Compensation Representative/HR within 24 hours of notification of the accident/injury

Employee: _____ **Date of Injury:** _____ **Time of Injury:** _____ **(Circle) AM PM**

Dept/Div: _____ **Supervisor:** _____ **Phone No:** _____

Job Title: _____ **Date Notified of Accident:** _____ **Date of Investigation:** _____

Shift: A ☐ B ☐ C ☐ **Start Time of Work Day:** _____ **: (Circle) AM PM** **Medical Treatment Provided (Circle) Y N**

Witnesses (attach statement for each)

Name: _____ **Title:** _____ **Phone Number:** _____

Name: _____ **Title:** _____ **Phone Number:** _____

Name: **Title:** **Phone Number:**

Describe the events immediately prior to the injury and the circumstances causing the employees' injury:

_____

_____

_____

Personal Protection Required (PPE): ☐ Foot Prot. ☐ Face/Eye Prot. ☐ Fall Prot. ☐ Respiratory Prot. ☐ Hand Prot.

☐ Head Prot. ☐ Lifting Assistance Device ☐ Apron/Chaps ☐ Back Belt ☐ Other: _____

☐ None Was PPE being used? ☐ Yes ☐ No Was injury caused by failure of the device(s) Yes ☐ No ☐

Object, equipment, or substance, which caused injury:

Choose factor (s), which directly or indirectly caused the accident to occur:

☐ Lack of Skill/Abilities	**☐ Physical Weakness/Disability**	**☐ Carelessness**	**☐ Unsafe Act**
☐ Failure to Use PPE	**☐ Failure to Follow Procedures**	**☐ Unsafe Condition**	**☐ Undetermined**
☐ Sudden Distraction	**☐ Fatigue**	**☐ Client Assault**	**☐ Client Caused**

Other-Describe _____

Other Factors:

☐ Poor Workplace Design	**☐ Broken/Damaged Equipment/Object**	
☐ Inadequate Procedures	**☐ Inadequate Resources**	**☐ Actions by Another Person/Employee**

☐ Other-Describe:

Are your findings consistent with employee's description? Yes ☐ No ☐

Describe accident if different from employee's description: _____

_____

Describe actions taken to prevent reoccurrence:

_____

_____

Make recommendations to the Safety and Health Director/Committee. Provide additional attachments as required.

Supervisor's Signature: _____ **Title:** **Date:**

Dept. Head/Area Administrator Initials: **Date:**

Attachments: Witness Statements **Distribution:**

DHHS S & B Form 3010 S (06/30/09)